



Facility Name & ID Number St Joseph's Home For The Elderly

# 0027045 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 06/28/01

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>20</u>	Skilled (SNF)	<u>20</u>	<u>7,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>31</u>	Intermediate (ICF)	<u>31</u>	<u>11,315</u>	3
4		Intermediate/DD			4
5	<u>7</u>	Sheltered Care (SC)	<u>16</u>	<u>4,238</u>	5
6		ICF/DD 16 or Less			6
7	<u>58</u>	TOTALS	<u>67</u>	<u>22,853</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>9,817</u>	<u>2,169</u>		<u>11,986</u>	10
11	ICF/DD					11
12	SC	<u>2,524</u>	<u>4,127</u>		<u>6,651</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,341</u>	<u>6,296</u>		<u>18,637</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.55%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?  
Date started 01/09/1967

J. Was the facility purchased or leased after January 1, 1978?  
YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?  
YES ☐ NO ☒ If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Joseph's Home For The Elderly # 0027045 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	272,389	3,316	32,835	308,540		308,540	(83,334)	225,206			1
2	Food Purchase		66,694		66,694		66,694		66,694			2
3	Housekeeping	4,823	17,946	243,521	266,290		266,290		266,290			3
4	Laundry	61,446	6,288	26,268	94,002		94,002	(11,418)	82,584			4
5	Heat and Other Utilities			192,112	192,112		192,112	(128,076)	64,036			5
6	Maintenance	155,341	31,414	130,219	316,974		316,974	(13,321)	303,653			6
7	Other (specify):*	35,907		35,617	71,524		71,524		71,524			7
8	<b>TOTAL General Services</b>	529,906	125,658	660,572	1,316,136		1,316,136	(236,149)	1,079,987			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	964,163	44,510	210,344	1,219,017		1,219,017		1,219,017			10
10a	Therapy	44,694	2,404	2,903	50,001		50,001		50,001			10a
11	Activities	44,483	20,027	7,794	72,304		72,304		72,304			11
12	Social Services	14,736			14,736		14,736		14,736			12
13	Nurse Aide Training											13
14	Program Transportation			1,555	1,555		1,555		1,555			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,068,076	66,941	224,996	1,360,013		1,360,013		1,360,013			16
	<b>C. General Administration</b>											
17	Administrative			12,000	12,000		12,000		12,000			17
18	Directors Fees											18
19	Professional Services			48,248	48,248		48,248		48,248			19
20	Dues, Fees, Subscriptions & Promotions			124,874	124,874		124,874	(107,387)	17,487			20
21	Clerical & General Office Expenses	173,983	17,830	193,095	384,908		384,908		384,908			21
22	Employee Benefits & Payroll Taxes			323,754	323,754		323,754		323,754			22
23	Inservice Training & Education			3,040	3,040		3,040		3,040			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,666	4,666		4,666		4,666			25
26	Insurance-Prop.Liab.Malpractice			24,780	24,780		24,780	(3,987)	20,793			26
27	Other (specify):* <b>Bad Debts</b>			25,365	25,365		25,365	(25,365)				27
28	<b>TOTAL General Administration</b>	173,983	17,830	759,822	951,635		951,635	(136,739)	814,896			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,771,965	210,429	1,645,390	3,627,784		3,627,784	(372,888)	3,254,896			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			479,957	479,957		479,957	(64,466)	415,491			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			479,957	479,957		479,957	(64,466)	415,491			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			27,923	27,923		27,923		27,923			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			27,923	27,923		27,923		27,923			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,771,965	210,429	2,153,270	4,135,664		4,135,664	(437,354)	3,698,310			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(83,334)	1		4
5	Telephone, TV & Radio in Resident Rooms	(2,588)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(11,418)	4		8
9	Non-Straightline Depreciation	(64,466)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(125,488)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(13,321)	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(3,987)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,365)	27		24
25	Fund Raising, Advertising and Promotional	(107,387)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (437,354)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the  
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (437,354)		37

\*These costs are only allowable if they are necessary to meet minimum  
licensing standards. Attach a schedule detailing the items included  
on these lines.

C. Are the following expenses included in Sections A to D of pages 3  
and 4? If so, they should be reclassified into Section E. Please  
reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## Summary A

**12/31/2001**

[illegible]

## Summary B

**Facility Name & ID Number**

# 0027045

**Report Period Beginning:**

**01/01/2001**

### Ending:

**12/31/2001**

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Little Sisters of the Poor - Chicago Province, Inc.	Palatine, IL	Religious Order
				Little Sisters of the Poor - St. Mary's Home	Chicago, IL	Nursing Home

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ -0-			\$ -0-	\$ * -0-	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number      St Joseph's Home For The Elderly      #    0027045    Report Period Beginning:      01/01/2001      Ending:    2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☐      NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      N/A  
Street Address      \_\_\_\_\_  
City / State / Zip Code      \_\_\_\_\_  
Phone Number      (       )  
Fax Number      (       )

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Little Sisters of the Poor						\$		\$			\$	1	
2	- Chicago Province, Inc.	X		Construction	NONE	Various		4,363,320		4,363,320	Various	0.0300	-0-	2
3													3	
4													4	
5													5	
	Working Capital													
6													6	
7													7	
8													8	
9	TOTAL Facility Related						\$	4,363,320	\$	4,363,320			\$ -0-	9
	B. Non-Facility Related*													
10	Little Sisters of the Poor												10	
11	- Chicago Province, Inc.	X		Convent Allocation	NONE	Various		836,680		836,680	Various	0.0300	-0-	11
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	836,680	\$	836,680			\$ -0-	14
15	TOTALS (line 9+line14)						\$	5,200,000	\$	5,200,000			\$ -0-	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2000 report.				\$	-0-	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	-0-	2
3. Under or (over) accrual (line 2 minus line 1).				\$	-0-	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	-0-	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	-0-	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND   \$                      For    19                      Tax Year.    (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	-0-	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	-0-	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1996	-0-	8		
		1997	-0-	9		
		1998	-0-	10		
		1999	-0-	11		
		2000	-0-	12		
				13	FROM R. E. TAX STATEMENT FOR 2000    \$	13
				14	PLUS APPEAL COST FROM LINE 5                      \$	14
				15	LESS REFUND FROM LINE 6                      \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates    RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

St Joseph's Home For The Elderly

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0027045

CONTACT PERSON REGARDING THIS REPORT

Mother Benedict Armstrong

TELEPHONE ( 847) 358-5700

FAX #: (847) 358-5719

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    YES    NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 119,979

B. General Construction Type: Exterior Brick Frame Number of Stories 3

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

32 APTS. INDEPENDENT LIVING FACILITIES - NOT a separate entity. Facility is NOT run as a business, but is a part of the mission of the Little Sisters of the Poor - taking care of the elderly poor. See page 23A for additional information. Expenses for the apartments are NOT included in this cost report.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Existing Structure	653,400	1966	\$ 76,284	1
2					2
3	TOTALS	653,400		\$ 76,284	3

Facility Name &amp; ID Number    St Joseph's Home For The Elderly

#    0027045

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	67		1966	1966	\$ 3,221,573	\$ 95,983	40	\$ 80,539	\$ (15,444)	\$ 2,804,238	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Health Related Renovation			1967	24,177	721	40	604	(117)	20,628	9
10	Health Related Renovation			1968	34,542	1,029	40	863	(166)	28,760	10
11	Health Related Renovation			1969	26,308	784	40	658	(126)	21,361	11
12	Health Related Renovation			1970	40,716	1,213	40	1,018	(195)	32,219	12
13	Health Related Renovation			1971	22,307	665	40	558	(107)	16,963	13
14	Health Related Renovation			1972	119,419	3,558	40	2,986	(572)	89,554	14
15	Health Related Renovation			1974	10,272	306	40	257	(49)	7,275	15
16	Health Related Renovation			1975	9,671	288	40	242	(46)	6,655	16
17	Health Related Renovation			1976	965	29	40	24	(5)	643	17
18	Health Related Renovation			1978	44,279	1,319	40	1,107	(212)	27,246	18
19	Interior Renovation - Conversion from Wards to Rooms			1983	3,663,633	109,154	40	91,591	(17,563)	1,760,915	19
20	New Fire Door System			1984	25,217	751	40	630	(121)	11,276	20
21	Complete Boiler Renovation			1985	470,291	14,012	40	11,757	(2,255)	198,147	21
22	Electrical Repairs & New Cooling System for Boilers			1987	106,618	3,177	40	2,666	(511)	39,399	22
23	Concrete Restoration			1990	111,172	3,312	40	2,779	(533)	32,525	23
24	Exterior Renovation Including New Windows			1991	317,750	9,467	40	7,944	(1,523)	84,672	24
25	Driveway Restored			1991	32,334	1,927	10	1,198	(729)	32,334	25
26	Sewer Renovation			1992	13,999	417	40	350	(67)	3,358	26
27	Asbestos Removal & Central Air Conditioning			1992	1,051,235	31,320	40	26,281	(5,039)	261,687	27
28	Remodel Center & West Wings			1993	2,619,173	78,035	40	65,479	(12,556)	550,996	28
29	Pond Dredge			1995	24,711	2,104	14	1,765	(339)	11,473	29
30	Back Driveway Replaced			1996	57,358	6,836	10	5,736	(1,100)	31,548	30
31	Patio and Sidewalk Restoration			1998	27,055	3,225	10	2,706	(519)	9,471	31
32	Asphalt Paving			1998	1,888	224	10	188	(36)	658	32
33	Front Walkway Lighting Restoration			1998	2,892	344	10	289	(55)	1,011	33
34	Brick Paving, Concrete and Electric for Front Walkway/Sitting Area			2000	11,634	1,386	10	1,163	(223)	1,745	34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name &amp; ID Number    St Joseph's Home For The Elderly

#    0027045

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	1996 Cap Building Repairs - Valves, Sewer, Landscape	1996	\$ 24,091	\$	5	\$ 2,410	\$ 2,410	\$ 24,091	37
38	1997 Cap Building Repairs - Fire Alarm & Boiler Repair	1997	21,338		5	4,268	4,268	19,206	38
39	1998 CBR - B-Room Floor, Patio Flash, Door & Fire Alarm Panel	1998	8,558		5	1,712	1,712	5,992	39
40	1999 Cap Building Repairs - Mechanical Valve Repair	1999	2,349		5	470	470	1,175	40
41	2000 Cap Bldg Repairs - Repair to Trans Equip & Fire System	2000	4,026		5	805	805	1,208	41
42	2001 Cap Bldg Repairs - Windows, Flooring & Asbestos	2001	35,129		5	3,513	3,513	3,513	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,186,680	\$ 371,586		\$ 324,556	\$ (47,030)	\$ 6,141,942	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	1974 IH Cub Tractor	1974	\$ 1,510	\$	\$	\$	5	\$ 1,510	76
77	Care Use	1989 M/F Diesel Tractor	1989	21,817				4	21,817	77
78	Care Use	1987 Ford Mini Bus	1986	36,054				4	36,054	78
79	Care Use	1987 Ford Truck	1987	12,793				4	12,793	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Care Use	1994 Lewis Riding Mower	1994	\$ 5,807	\$	\$	\$	4	\$ 5,807
77	Care Use	1996 Chev Lumina Van	1996	15,118				4	15,118
78	Care Use	1997 Chevy Astro Van	1997	14,852	2,213	1,857	(356)	4	14,852
79	Care Use	1998 Steer-Rite Pallet Tr	1998	470	140	118	(22)	4	413
80	TOTALS		\$	\$	\$	\$			\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	1999 GreatChariot Mower	1999	\$ 6,521	\$ 1,943	\$ 1,630	\$ (313)		\$ 4,075	76
77	Care Use	1999 Ford Taurus Wagon	1999	14,409	4,293	3,602	(691)		9,005	77
78	Care Use	2000 Dodge Ram Van	1999	19,703	5,870	4,926	(944)		12,315	78
79	Care Use	1988 Ford Tempo	2000	2,098	625	525	(100)		787	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 700,309	\$ 86,661	\$ 72,717	\$ (13,944)	10 Years	\$ 398,358	71
72	Current Year Purchases	70,260	4,643	3,896	(747)	10 Years	3,896	72
73	Fully Depreciated Assets	295,283				10 Years	295,283	73
74								74
75	TOTALS	\$ 1,065,852	\$ 91,304	\$ 76,613	\$ (14,691)		\$ 697,537	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Care Use	1995 Nissan Pathfinder	2000	\$ 2,098	\$ 625	\$ 525	\$ (100)	4	\$ 787
77	Care Use	1992 Plymouth Acclaim	2001	3,239	483	405	(78)	4	405
78	Care Use	1995 Buick Skylark	2001	5,874	875	734	(141)	4	734
79									
80	TOTALS			\$ 162,363	\$ 17,067	\$ 14,322	\$ (2,745)		\$ 136,472

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	13,491,179
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	479,957
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	415,491
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(64,466)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	6,975,951

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bldg - Convent Allocation Various	\$ 2,318,523	\$ 60,208	\$ 984,811	86
87	Equip - Convent Allocation Various	204,380	14,691	208,713	87
88	Vehicles - Convent Allocation Var	31,134	2,745	26,168	88
89					89
90					90
91	TOTALS	\$ 2,554,037	\$ 77,644	\$ 1,219,692	91

G. Construction-in-Progress			
	Description	Cost	
92	NONE	\$ -0-	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease.

9. Option to Buy:

YES

NO

Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES

NO
16. Rental Amount for movable equipment: \$Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning   
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<div></div> /2002	\$ <div></div>
13.	<div></div> /2003	\$ <div></div>
14.	<div></div> /2004	\$ <div></div>

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

\* ALL AIDES EMPLOYED HAVE PREVIOUSLY OBTAINED THE NECESSARY TRAINING

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 146,684	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000 )	240,842		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	2,569		5
6	Prepaid Insurance	21,268		6
7	Other Prepaid Expenses	24,587		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Donations Receivable	100,340		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 536,290	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,387		13
14	Buildings, at Historical Cost	14,409,712		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,463,729		16
17	Accumulated Depreciation (book methods)	(8,067,294)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 7,917,534	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 8,453,824	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 105,822	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,421		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 136,243	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	5,200,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,200,000	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,336,243	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,117,581	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 8,453,824	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 673,693	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 673,693	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,443,888	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,443,888	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,117,581	24 *

\* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,743,512	1
2	Discounts and Allowances for all Levels	(483,580)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,259,932	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,000	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,000	23
D. Non-Operating Revenue			
24	Contributions	5,326,272	24
25	Interest and Other Investment Income***	(10,652)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,315,620	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,579,552	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,316,136	31
32	Health Care	1,360,013	32
33	General Administration	951,635	33
B. Capital Expense			
34	Ownership	479,957	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	27,923	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,135,664	40
41	Income before Income Taxes (line 30 minus line 40)**	2,443,888	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,443,888	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing	1,897	2,221	57,950	26.09	2
3	Registered Nurses	15,116	17,082	355,220	20.79	3
4	Licensed Practical Nurses	3,390	3,533	59,167	16.75	4
5	Nurse Aides & Orderlies	30,533	34,495	457,634	13.27	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,650	2,984	44,694	14.98	8
9	Activity Director	2,023	2,368	33,426	14.12	9
10	Activity Assistants	1,021	1,121	11,057	9.86	10
11	Social Service Workers	1,058	1,089	14,736	13.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,388	26,431	272,389	10.31	15
16	Dishwashers					16
17	Maintenance Workers	7,390	8,672	155,341	17.91	17
18	Housekeepers	101	487	4,823	9.90	18
19	Laundry	5,968	6,619	61,446	9.28	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,107	13,189	173,983	13.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,725	2,083	34,192	16.41	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security Guards</u>	2,180	2,557	35,907	14.04	33
34	TOTAL (lines 1 - 33)	110,547	124,931	\$ 1,771,965 *	\$ 14.18	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	99	\$ 3,448	1-3	35
36	Medical Director	96	2,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	26	794	10-3	39
40	Physical Therapy Consultant	59	2,903	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	280	\$ 9,545		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	401	\$ 14,817	10-3	50
51	Licensed Practical Nurses	15	528	10-3	51
52	Nurse Aides	32	666	10-3	52
53	TOTAL (lines 50 - 52)	448	\$ 16,011		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Repair of Manhole	08/98	\$ 2,433	3 Yrs	\$ 338	\$ 811	\$ 811	\$ 473	\$	\$	\$	\$	\$
2	Repair of Boiler	06/99	2,061	3 Yrs		401	687	687	286				
3	Painting	01/2001	3,474	3 Yrs				1,158	1,158	1,158			
4	Plumbing Repairs	08/2001	2,655	3 Yrs				369	885	885	516		
5	Painting	11/2001	4,825	3 Yrs				268	1,608	1,608	1,341		
6	Plumbing Repairs	11/2001	2,836	3 Yrs				158	945	945	788		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 18,284		\$ 338	\$ 1,212	\$ 1,498	\$ 3,113	\$ 4,882	\$ 4,596	\$ 2,645	\$	\$

Facility Name & ID Number		St Joseph's Home For The Elderly		STATE OF ILLINOIS	#	0027045	Report Period Beginning:	01/01/2001	Ending:	12/31/2001	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>No</u> <u>N/A</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>No</u> <u>N/A</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>1,520</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>      </u> NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>27,923</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.			<u>Yes</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?			\$ <u>-0-</u> <u>No</u> Indicate the amount. \$ <u>-0-</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>25% for</u>							
	d. Have vehicle usage logs been maintained?			<u>Yes</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>Yes</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>Yes</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?			<u>Yes</u> <u>Varey &amp; Vaccariello CPAs PC</u> <u>Yes</u> If no, please explain. <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Attach invoices and a summary of services for all architect and appraisal fees			<u>N/A</u>							